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In the Supreme Court of the United States

OCTOBER TERM, 1994

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES, *et al.*,
Petitioners,

v.

HEALTH INSURANCE ASSOCIATION OF AMERICA, INC. AND BLUE CROSS AND BLUE SHIELD ASSOCIATION,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the District of Columbia Circuit

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BRIEF IN OPPOSITION

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COUNTERSTATEMENT OF QUESTIONS PRESENTED

Whether the Court of Appeals correctly applied this Court's decision in *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), to invalidate two new Health Care Financing Administration regulations.

Whether the Court of Appeals correctly applied this Court's decision in *Bowen v. Georgetown University Hospital*, 488 U.S. 204 (1988), to determine that two other new Health Care Financing Administration regulations may not be applied retroactively.

RULE 29.1

In accordance with Rule 29.1 of the rules of this Court, respondents are the Blue Cross and Blue Shield Association and the Health Insurance Association of America, Inc. Both the Blue Cross and Blue Shield Association and the Health Insurance Association of America, Inc. are not-for-profit corporations with no parent corporations or subsidiaries.

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BRIEF IN OPPOSITION

This case concerns the straightforward determination by the Court of Appeals that (1) certain regulations adopted by the Health Care Financing Administration ("HCFA") exceed the authority of the agency under the governing statute; and (2) certain other regulations adopted by the agency may not be applied retroactively. In making this determination, the Court of Appeals applied well-settled principles of law, not disputed by the parties, undertook a careful examination of the statute in question, and addressed no important jurisprudential questions. The Court of Appeals went on to deny without dissent the government's petition for rehearing and suggestion for rehearing *en banc*.

It is obvious from the government's Petition—which is almost entirely devoted to rearguing the merits of the

case—that none of the traditional grounds on which this Court grants review is presented here. The government concedes that the Court of Appeals' decision has created no conflict among the circuits, and that no conflict is likely to occur. Moreover, nowhere does the government show why this case presents any question of such widespread significance that this Court should review agency regulations that the Court of Appeals found wanting under well-settled principles of statutory construction established by this Court.[1] To be sure, the government disagrees with the Court of Appeals and asserts that the decision below will frustrate the operation of the governing statute. But if that were enough to merit review by this Court, then every case invalidating an agency regulation would warrant certiorari.

Furthermore, it is quite clear that these particular regulations are plainly *not* authorized by the statute at issue. It is also quite clear that these regulations—which mark a radical break with the agency's original understanding of its powers—were belatedly and inappropriately adopted by the agency merely to address its own failures in administering the statute, failures that Congress recently has seen fit to address on its own. In sum, the decision of the Court of Appeals does not warrant review by this Court and the petition for a writ of certiorari should therefore be denied.

COUNTERSTATEMENT OF THE CASE

The government's Statement of the Case omits and misstates important information concerning the factual and the legal context of this case.

1. Contrary to the implications of the government's Petition, the Medicare as Secondary Payer ("MSP") statute, 42 U.S.C. § 1395y(b), *et seq.*, was not designed as

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[1] *See Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984); *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204 (1988).

a federal program to regulate the terms of private health insurance. Rather, the MSP statute adopted the private insurance industry practice of "coordinating," that is, determining an order of payment for, two sources of insurance that cover the same medical expense for the same individual. Such coordination of benefits does *not* change the terms or conditions of any insurance coverage; instead, it merely resolves which source of coverage will pay first under the terms of its coverage, with the secondary source paying under its coverage all or part of the expenses that have not been covered by the primary payer. In the MSP statute, Congress borrowed these coordination of benefits principles from the private sector, in HCFA's own words, to "merely change the order of Medicare payments when private insurance is available," making Medicare a secondary payer. 48 Fed. Reg. 14,804 (1983).

a. As the Court of Appeals observed, the structure of the statute is relatively simple and direct. Pet. App. 3a.[2] First, Congress commands HCFA not to make a Medicare payment if "payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1)." 42 U.S.C. § 1395y(b)(2)(A)(i). The "paragraph (1)" to which this provision refers in turn requires an employer group health plan ("EGHP") to offer Medicare beneficiaries who are working or who have EGHP coverage through their working spouses the same benefits under the same conditions that are offered to all current employees and their spouses who are not yet eligible for Medicare.[3] 42 U.S.C. § 1395y(b)(1). Thus, while the provisions of an EGHP may not be manipulated for its Medicare-eligible beneficiaries to avoid the status of Medicare as a secondary payer, nothing in the MSP statute otherwise goes beyond this mere *ordering*

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[2] "Pet. App." denotes the Appendix to the Petition for a Writ of Certiorari.

[3] The MSP provisions at issue here also apply to beneficiaries with end-stage renal disease and to those who are disabled yet still working. Petition for a Writ of Certiorari ("Pet.") 5-6.

of health care benefits to mandate what *coverage* an EGHP must offer or the *conditions* under which it is offered. Indeed, the trigger for the MSP statute is the *terms* of the EGHP: *only* when an EGHP provides coverage that duplicates that of Medicare does the MSP statute make Medicare a secondary payer.

Second, if HCFA fails to obey its statutory obligation and pays primary when it should not, its payments are "conditioned on reimbursement . . . when notice or other information is received" that payment for the service "has been or could be made" by another payer under an EGHP. 42 U.S.C. § 1395y(b)(2)(B)(i). In order to accomplish this reimbursement, HCFA is subrogated to the rights of the beneficiaries and providers who actually received payments from HCFA. 42 U.S.C. § 1395y(b)(2)(B)(iii). HCFA is authorized to bring suit against any entity "required or responsible . . . to pay . . . under a primary plan" for the service at issue to compel such reimbursement. 42 U.S.C. § 1395y(b)(2)(B)(ii). Thus, the constant point of reference for the government's recovery rights under the MSP statute is the terms of a given EGHP.

b. Although Congress enacted MSP amendments in 1980, 1981, and 1982, Pet. 5-6, HCFA did not find it necessary to promulgate regulations to implement the statute until 1983. Consistent with the agency's understanding that "[t]he legislative provisions we are implementing are relatively detailed and precise and allow minimal discretion to the Secretary," 48 Fed. Reg. 15,906 (1983), HCFA's original MSP regulations contained no provisions with anything like the two regulations at issue in this case. *See* 48 Fed. Reg. 14,802 (1983) and 48 Fed. Reg. 15,902 (1983).

In order to secure reimbursement when an EGHP had improperly failed to make a primary payment, the 1983 rules authorized HCFA to "[b]ring an action against the employer or the [employer group health] plan as appropri-

ate," 42 C.F.R. § 405.344(b)(2)(i) (1983) (superseded); but no mention was made of third party administrators ("TPAs")—essentially claims-processors—as entities from whom recovery could be sought. Nor did the regulations seek to mandate or override the terms governing EGHP coverage, such as those addressing claims-filing deadlines and treatment pre-approval requirements.

When Congress amended the MSP statute in 1984 by explicitly subrogating HCFA to the rights of an EGHP's beneficiary and authorizing HCFA to sue to recover whatever might be due from an EGHP,[4] HCFA did not initially promulgate regulations because, in the agency's words, "the new legislation relating to [the] Medicare . . . program [is] sufficiently complete and clear that we believe [it] can take effect without issuance of regulations." 50 Fed. Reg. 28,989 (1985). As the agency stated, the new MSP amendments were "in whole or in large part, self-explanatory" and "so clear and explicit that regulations are not required for their implementation." *Id.* at 28,988. Indeed, although HCFA subsequently amended the regulations in ways not here relevant, the agency continued to characterize the 1984 legislation as "allow[ing] only very limited discretion in the implementation of the statute." 50 Fed. Reg. 41,509 (1985).

c. In late 1989, however, HCFA completely changed its view of the meaning of the MSP statute and its authority under the statute—even though Congress had not changed the statute—and promulgated new MSP regulations that marked a sharp departure from its original rules. The two new rules at issue here essentially create private insurance or TPA liability by agency fiat where none previously existed under the terms of private contracts.

The claims-filing override regulation, 42 C.F.R. § 411.24(f), makes Medicare a secondary payer to an EGHP even

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[4] The Deficit Reduction Act of 1984 ("DEFRA"), Pub. L. No. 98-369, Tit. III § 2344, 98 Stat. 494, 1095-96; 42 U.S.C. §§ 1395y(b)(1), (2)(B) and (3)(A)(ii) (Supp. II 1984).

where that EGHP has no payment responsibilities under the terms of its coverage. Specifically, that regulation compels reimbursement to HCFA of Medicare payments "without regard to any claims filing requirements that the insurance program or plan imposes on the beneficiary or other claimant such as a time limit for filing a claim or a time limit for notifying the plan or program about the need for or receipt of services."[5] The claims-filing deadlines HCFA seeks to override are common in EGHPs and insurance contracts; they are critical to an insurer's ability to investigate the merits of a claim, to have a defined period for its liabilities, and to assess premiums on an actuarially sound basis as required by state law. C.A. App. 150-52 (Leonard Wood Aff.); 210-13 (Robert Miller Aff.). A typical notice of claim provision gives the insured one year in which to file a claim, with a grace period of an additional year where it was not reasonable to meet the first deadline. C.A. App. 152 (Leonard Wood Aff.). Not only is there no evidence in the record that such a period is unreasonably short, but the government concedes that Medicare receives and pays claims before the expiration of EGHP claims-filing deadlines "in the vast majority of cases." Pet. 16 n.11. HCFA itself requires Medicare beneficiaries to submit Medicare claims within a period not exceeding two years from the date of the medical service involved, a condition HCFA considers to be one

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[5] In the course of this litigation, HCFA claimed that its new rule, in spite of its clear text, does *not* override preapproval requirements for certain services because "HCFA recognizes the cost-savings implications of these programs and supports them." Joint Appendix in *HIAA v. Shalala*, Nos. 92-5196 & 92-5197 (D.C. Cir., filed July 30, 1993) ("C.A. App.") at 413 (Paul Olenick Aff.). Since the rule expressly overrides "a time limit for notifying the plan or program about the need for or receipt of services," the Court of Appeals properly dismissed HCFA's protestations as "absurd." Pet. App. 15a. Nevertheless, the Court of Appeals accepted the agency's interpretation of its regulation for purposes of this litigation. That portion of the regulation is therefore not at issue before this Court.

of the "[b]asic requirements for all [Medicare] claims." *See* 42 C.F.R. §§ 424.32 and 424.44.

The other rule at issue in this case, the TPA regulation, 42 C.F.R. § 411.24(e), expands the class of entities legally and financially liable for the benefits of an EGHP to entities who have not contractually assumed that liability, that is, to TPAs who are hired to process and pay claims where an employer chooses to "self-insure" its EGHP.[6] C.A. App. 157-58 (Leonard Wood Aff.); 205 (Robert Miller Aff.); 221-22 (Harvie Raymond Aff.). As the Court of Appeals explained, these "administrators customarily do not pay the financial obligations of their plan customers from their own funds or commingle plan funds with their own funds." Pet. App. 6a (citation omitted). The impact of this rule on TPAs is dramatic for it essentially provides that no person or entity can serve only as a claims processor, but must be ready to compensate Medicare—in essence, to insure Medicare—when Medicare improperly makes a primary payment. Moreover, because of the agency's "pay and chase" policy (discussed *infra*, pp. 9-10), claims against these entities are likely to come years after their contractual relationship with the employer or EGHP has ended, when they are unlikely to have access to funds with which to make repayment. C.A. App. 157-58 (Leonard Wood Aff.); 205-06, 209 (Robert Miller Aff.); 221 (Harvie Raymond Aff.).

2. The agency's justification for rules that reversed its own past statutory interpretation and threatened such a dramatic impact on private health benefit arrangements

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[6] Insurance companies may be hired to perform these claims-processing chores, but one third of claims processors are small companies who provide only contract administration services, primarily to large companies choosing to self-insure their EGHPs. Brief of *Amicus Curiae* Self-Insurance Institute of America, Inc. in *HIAA v. Shalala*, Nos. 92-5196 & 92-5197 (D.C. Cir., filed Aug. 13, 1993) at 11 n.14. The cited brief was relied upon below by both Judge Williams and Judge Henderson. Pet. App. 6a, 33a.

was that "implementation [of the MSP statute had] fallen short of expectations." 53 Fed. Reg. 22,335 (1988). Yet the explanation HCFA gave for this shortfall had nothing to do with the two regulations at issue, but rested instead on government studies revealing that *hospitals* failed to obtain complete information on possible dual coverage before submitting a claim directly to Medicare for payment. *Id. See also* 54 Fed. Reg. 41,716 (1989) (publication of final rules).

Moreover, HCFA itself has touted the considerable savings actually achieved by the MSP statute. For example, the agency reported that for fiscal year 1988, the year before the regulations at issue were promulgated, almost $2 billion was saved.[7] Two years later, the Administrator of HCFA testified in a Senate hearing that, "[w]e believe we have an effective secondary payer program, as the $2.2 billion savings [in FY 1989] demonstrate." Hearing Before the Perm. Subcomm. on Investig., Senate Comm. on Gov't Affairs, 101st Cong., 2d Sess. (1990) (testimony of G. Wilensky, Admin. HCFA) at 55. This was a trend of savings that the Administrator expected to continue. *Id.* at 57.

Notwithstanding this history, the government's Petition now adverts to alleged additional savings ranging from "hundreds of millions of dollars" (Pet. 15) to "approximately $3 billion" (*id.* at 26). But the government makes no effort to document or even describe for this Court the problem that prevents savings of such undefined magnitude; nor does it show how those suggested "savings" are related to the two HCFA regulations at issue. Instead, the government simply states—with no basis in fact or in the record—that these alleged additional savings constitute

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[7] Act. HCFA Admin. Louis B. Hays, Memo. to Health and Human Services Insp. Gen. commenting on Draft *Management Advisory Report: Medicare as Secondary Payer—A Restitution Proposal*, AO-12-89-00002 (Sept. 21, 1989) at 3 (appended to final published report).

"a windfall of like proportions" to EGHPs (*id.* at 15) and contends without explanation or justification that this litigation is merely a stratagem "to preempt the Secretary's ability . . . to recover" this "windfall" (*id.* at 14-15).[8]

Worse, the government fails to acknowledge the primary reason more money has not been saved by the MSP statute: the fact that at the outset HCFA adopted a "pay and chase" procedure under which it simply paid claims without first obtaining any information whether the claimant also had EGHP coverage that was primary under the MSP statute. The only court to have examined this agency approach condemned it, concluding that it is "particularly egregious with respect to those claims for services submitted solely to the Government, of which [the insurer] would have no knowledge. Clearly, each time the Government makes a mistaken Medicare overpayment, it violates its statutory duty not to make such a payment." *Provident Life & Accident Ins. Co. v. United States*, 772 F. Supp. 1016, 1025 (E.D. Tenn. 1991).

HCFA's "pay and chase" policy has furthermore been the subject of consistent criticism by the government it-

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[8] The government's implication of widespread wrongdoing by EGHPs or insurers is not only unsubstantiated, but simply untrue. As noted, the studies on which HCFA relied to justify the 1989 rules identified the behavior of hospitals, not EGHPs or insurers, as a problem. Moreover, the government elsewhere has acknowledged that official studies of the MSP statute have given "no indication that there [is] any industry-wide noncompliance by insurance companies." U.S. Brief on Tolling Statute of Limitations, *Provident Life & Accident Ins. Co. v. United States*, CIV-1-89-190 (E.D. Tenn., filed Jan. 4, 1992) at 10 (Appendix E to Respondent's main brief below). Finally, Medicare overpayments do not in any case constitute a "windfall" for insurance companies because they are not made to insurers but to health care providers or beneficiaries. And the premium charged by insurers, as the uncontested record here shows, is generally a function of actual claims of beneficiaries that the EGHP paid during the prior year, and other expenses actually incurred. *See* C.A. App. 147-48 (Leonard Wood Aff.). If claims have not been presented to and paid by an EGHP, they are *not even reflected* in the premium paid to the insurer.

self. Just this year, for example, the General Accounting Office concluded: "This 'pay and chase' approach is widely recognized as more costly and less effective than a cost avoidance approach. The more efficient cost avoidance approach seeks to identify the other insurance, bill the insurer, and receive payment prior to billing Medicare as secondary payer." U.S. Gen. Acct. Off., *Medicare/ Medicaid: Data Bank Unlikely to Increase Collections from Other Insurers*, GAO/HEHS-94-147 (May 1994) at 11.[9]

Aggravating the impact of "pay and chase" has been HCFA's resistance, despite repeated recommendations by the Inspector General of the Department of Health and Human Services ("HHS") and others, to implement a standard claim form requiring a beneficiary to identify or deny other sources of health care coverage before Medicare pays.[10] As the HHS Inspector General described HCFA's practice: "When this section of the claim form

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[9] As the GAO explained to a Senate committee recently:

> This labor-intensive process of communicating with private insurance companies to recover the mistaken payments after the fact is burdensome and expensive. This is the case not just for Medicare, but for the private insurance companies who must search their records, often dating back several years, to determine if, in fact, they were the primary payer.

Hearing Before the Subcomm. on Regulation of Gov't Info., Comm. on Governmental Affairs, 103d Cong., 1st Sess. 35 (April 12, 1993) (testimony of Leslie Aronovitz).

[10] U.S. Gen. Acct. Off., *Medicare: More Hospital Costs Should be Paid by Other Insurers*, GAO/HRD-87-43 (Jan. 1987) at 40; HHS, Off. of Insp. Gen., *Medicare as a Secondary Payment Source: Automobile Accident Related Claims*, OAI-07-86-00017 (Jan. 1988) at iii; HHS, Off. of Insp. Gen., *Medicare as a Secondary Payment Source: End-stage Renal Disease*, OAI-07-86-00092 (Jan. 1988) at iii; HHS, Off. of Insp. Gen., *Medicare as a Secondary Payment Source: Medicare Beneficiaries Covered by Employer Group Health Plans*, OAI-07-86-00091 (Feb. 1988) at iii-iv; HHS, Off. of Insp. Gen., *More Complete Employer Group Health Plan Information is needed to Administer the Medicare Secondary Payer Program*, A-09-89-00100 (March 20, 1990) at 7, 12.

is left blank, the Medicare claims processor assumes that there is no other health insurance coverage and the claim is processed and paid by Medicare." HHS, Off. of Insp. Gen., *More Complete Employer Group Health Plan Information is needed to Administer the Medicare Secondary Payer Program*, A-09-89-00100 (March 20, 1990) at 7.

In the situation described by the agency's Inspector General, neither the EGHP nor its insurer or TPA is even aware that one of its beneficiaries has incurred a medical expense because no claim has ever been presented to the EGHP. Instead, the claim has been presented to and improperly paid by HCFA. If HCFA would simply determine whether private coverage exists *before* making a payment, it could solve the problem it now complains of to this Court.[11] Indeed, the government's own studies show that simply by identifying the EGHP coverage of working spouses of Medicare beneficiaries, HCFA could achieve 97% of the potential additional MSP savings. HHS, Off. of Insp. Gen., *Medicare as a Secondary Payer: Unrecovered Funds*, OEI-07-90-00764 (June 29, 1990) at 4.

3. As the above makes clear, proposals for improving the operation of the MSP statute are matters of public policy and political judgment for Congress rather than legal questions for the courts. And, indeed, Congress has amended the MSP statute on several occasions since the challenged regulations were promulgated. For example, the Data Match program allows Medicare and tax information to be compared to identify Medicare beneficiaries who continue to work and so may be covered by an EGHP. *See* 42 U.S.C. § 1395y(b)(5)(A). And an em-

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[11] HCFA, and its contractors who administer Medicare, do not operate under any statutory mandate that is at odds with the command of the MSP statute not to make Medicare payments if private insurance coverage is available. Medicare contractors are required to pay Medicare claims promptly, but only if they are "clean claims," defined by Congress to include only claims that have no "lack of any required substantiating documentation." 42 U.S.C. §§ 1395h(c)(2)(B) and 1395u(c)(2)(B).

ployer may be contacted to determine if such an employee does in fact have such health care coverage. *See* 42 U.S.C. § 1395y(b)(5)(C).

In addition, Congress just recently ordered HCFA to mail questionnaires to new Medicare beneficiaries to determine whether they also have EGHP health coverage. 42 U.S.C. § 1395y(b)(5).[12] At the same time, Congress overcame HCFA's resistance to a standard claim form by prohibiting the agency from making payment under Part B of Medicare in the absence of a completed claim form identifying any private group health care coverage of a Medicare beneficiary. 42 U.S.C. § 1395y(b)(6).[13] These legislative changes reflect Congress' view of the best way to improve the MSP statute.

Finally, though the government mentions settlement discussions in two pending district court cases involving similar issues (Pet. 28), it omits reference to the settlement discussions pending in *this* case that were initiated at the invitation of the Solicitor General. These discussions are designed to address the *systemic* problems in the operation of the MSP statute. The government also omits that one component of such a settlement is the joint submission to Congress of the legislative changes needed to effect such reform. Thus, review by the Court —even a reversal of the decision below—cannot bring about the overall needed improvements in the MSP program.

4. Because HCFA attempted in 1989 to "improve" the MSP statute on its own by overriding private contracts and holding TPAs liable for HCFA's mistaken payments, respondents Health Insurance Association of America, Inc. ("HIAA") and Blue Cross and Blue Shield Association ("BCBSA") each filed lawsuits that, together, challenged the validity of five of HCFA's 1989 MSP rules, including 42 C.F.R. §§ 411.24(e) and (f), as well as the retroac-

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[12] Social Security Act Amendments of 1994, Pub. L. No. 103-432, Tit. I, § 151(a)(1)(A), 108 Stat. 4398, 4432 ("1994 Amendments").

[13] 1994 Amendments, § 151(a)(2), 108 Stat. 4433.

tive application of the rules. Although the district court upheld all the regulations, the Court of Appeals reversed the district court's judgment with respect to the issues presented here, finding that sections 411.24(e) and (f) exceeded the Secretary's statutory authority and that the 1989 rules could not be applied retroactively.

a. The panel unanimously held section 411.24(f) (the claims-filing override regulation) to be plainly unauthorized by the MSP statute. In so holding, the Court of Appeals recognized that HCFA's statutory right of action does not mandate the terms or conditions of private EGHP coverage, but rather permits HCFA to recover payment from entities who fail to pay benefits according to the terms of their own contractual obligations. As the Court noted, the statute enforces Medicare's position as a secondary payer when payment for a medical expense covered by Medicare "[1] has been made, or [2] can reasonably be expected to be made" under an EGHP. Pet. App. 17a. The Court of Appeals correctly concluded that payment by an EGHP "can reasonably be expected to be made" only when its conditions for coverage, including claims-filing deadlines, have been met. *Id.* The Court of Appeals pointed out further that the district court simply misquoted the statute when it said that the agency could seek reimbursement from an EGHP "when notice or other information is received that payment . . . *could have been* made" by the EGHP, because the statute actually reads "*could be* made." *Id.* (quoting 42 U.S.C. § 1395y(b)(2)(B)(i)). Thus, the Court of Appeals held, if no claim has been filed before a filing deadline has expired, payment could *not* be made. *Id.* at 17a n.6.

b. A majority of the panel also held that section 411.24(e) (the TPA regulation) was invalid, concluding that TPAs could not be treated as entities "required or responsible . . . to pay . . . under a plan" within the meaning of the MSP statute. Judge Henderson agreed with all three of the other courts addressing this issue [14]

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[14] *United States v. Travelers Ins. Co.*, 815 F. Supp. 521, 524 (D. Conn. 1992); *Provident Life & Accident Ins. Co. v. United*

that TPAs are not "responsible" entities under their own contracts or under the MSP statute for the medical expenses of individuals covered by the EGHPs they administer. Rather, they simply process claims and make payments on behalf of those who *are* "responsible." She therefore found HCFA's regulation "inconsistent with the plain text of the MSP statute." *Id.* at 35a. *See also id.* at 33a. Judge Williams, however, concluded that even a mere claims processor might be viewed as "responsible . . . to pay," in the sense that such an entity plays a role in paying the benefits of an EGHP. *Id.* at 36a. After examining the agency's rationale for imposing financial liability on such an entity, however, he concluded that the TPA regulation was not a reasonable construction of the statute, and thus was invalid because: (1) the agency's view would impose liability on any entity that happened to process payments, including banks; (2) the agency's view would impose liability on those who were expressly not liable under their contracts; and (3) the agency had not shown it would even be "inconvenienced" if it were required to proceed against those who were actually liable for payment. *Id.* at 9a-10a. Chief Judge Mikva dissented, finding that he should defer to the agency's view of the statute. *Id.* at 36a.

c. Finally, the Court of Appeals unanimously concluded that under this Court's decision in *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204 (1988), HCFA had no authority to apply its 1989 rules retroactively to transactions that predated their adoption. Pet. App. 23a-31a.[15] At the same time, the Court concluded that an agency interpretation could be applied retroactively in adjudication, provided such an interpretation was con-

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States, 740 F. Supp. 492, 504 (E.D. Tenn. 1990), *appeal dismissed*, 925 F.2d 1465 (6th Cir. 1991); *United States v. Blue Cross & Blue Shield of Michigan*, 726 F. Supp. 1517, 1521-22 (E.D. Mich. 1989).

[15] Those regulations were 42 CFR § 411.32(a)(1), the Medigap Restriction rule, and 42 CFR § 411.24(i), the Double Payment regulation.

sistent with "whatever pertinent rules were in effect at the time of the [past] transactions." *Id.* at 30a-31a.

REASONS FOR DENYING THE WRIT

The government seeks certiorari in this case on two grounds. First, it asserts that the case raises "important legal issues warranting review by this Court." Pet. 14. Second, it contends that the case is of "considerable practical significance to a major federal program." *Id.* at 26. In fact, however, the case raises no "important legal issue" at all, and involves nothing more than the Court of Appeals' construction of a federal statute in accordance with well-settled principles that this Court has established. In the end, the case simply presents the government's disagreement with the Court of Appeals about the validity of certain agency regulations. That disagreement is not enough to make this a certworthy case. The Petition should be denied.

I. THE COURT OF APPEALS RESOLVED THIS CASE BY APPLYING WELL-SETTLED PRINCIPLES ESTABLISHED BY THIS COURT.

Most of the government's Petition is intended to show that the Court of Appeals has misread the MSP statute. However, the government knows that this Court does not grant certiorari to correct alleged lower-court misreadings of statutes; the government therefore suggests that the Court of Appeals' misreading is based on a failure to follow significant legal principles of broad application. But the significant legal principles invoked by the government are not elements of this case at all. In fact, the Court of Appeals decided all three parts of this case—the claims-filing override regulation, the TPA regulation, and the retroactivity question—on the basis of well-settled principles.

a. With regard to the claims-filing override regulation, the Court of Appeals recognized—as does the government itself—that "[i]f the regulation has any statutory basis, it springs from HCFA's independent right to recover con-

ditional payments under the first two clauses of paragraph (2)(B) of the MSP Statute. . . ." Pet. App. 15a-16a. Yet, as the Court of Appeals pointed out, in several separate respects the plain language of these controlling statutory clauses contradicts the proposition that HCFA has been given power to seek recovery from private insurers who have no obligation to make payment under the terms of their own contracts. For example, as the Court of Appeals noted, under the statute the government may seek recovery "against 'any entity which is required or responsible under this subsection to pay . . . under a primary plan,'—not against an entity that would have been responsible to pay if the beneficiary (or other obligee) had followed proper procedures." *Id.* at 17a (citation omitted). Similarly, as the Court also noted, under the statute "HCFA can seek reimbursement from the plan 'when notice or other information is received that payment for such item or service . . . could be made under the plan,'—not (as the district court quoted the MSP statute to say) 'when notice or other information is received that payment for such item . . . could have been made, under the plan. . . .' " *Id.* (citations omitted).

The government's only effort to make this straightforward determination by the Court of Appeals into a certworthy issue is to assert that that reading is "based . . . exclusively on the verb tenses Congress used in various statutory phrases. . . ." Pet. 15. But as this Court's decisions teach, a verb is often the key determinant of Congress' intent. *See, e.g., Gwaltney of Smithfield, Ltd.* v. *Chesapeake Bay Foundation, Inc.*, 484 U.S. 49 (1987). *Accord, United States* v. *Wilson*, 112 S.Ct. 1351, 1354 (1992) ("Congress' use of a verb tense is significant in construing statutes"). Furthermore, the government is wrong to say that verb tenses were the "exclusive" underpinning of the Court's decision. The Court of Appeals' opinion not only canvassed the entire statutory framework in reaching its decision, but its opinion also analyzed the whole of the particular statutory provisions which had to

authorize the regulation—if it was authorized at all. Pet. App. 2a-5a, 14a-17a. And, as was true in *Gwaltney*, this canvassing and analysis confirmed that Congress' choice of tenses was deliberate and should be given effect.

Nevertheless, the government argues at length that the Court of Appeals was wrong. For example, it contends that the clause of the statute giving the agency an independent right of action was "intended to free the Secretary from procedural or other incidental limitations that might bar recovery on the beneficiary's own behalf." Pet. 17. But the government never points to *anything* in the statute or its history remotely supporting this viewpoint; nor does it suggest any limitations or criteria for this claimed broad power to override whatever provisions of private contracts the agency may deem "procedural" or "incidental." [16]

The government also contends that if it is not given power to override claims-filing provisions its "statutory right of recovery would often be time-barred before it even accrues." Pet. 18. By this, the government presumably means that private claims-filing requirements may expire before the agency has an opportunity for such recovery. Yet the government elsewhere concedes that "in the vast majority of cases, Medicare claims will be sub-

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[16] The government wrongly characterizes the Court of Appeals as holding that HCFA's statutory right to bring a lawsuit is subject to and governed by "*all* the terms . . . applicable to a beneficiary . . ." (Pet. 12) (emphasis supplied). To the contrary, respondents concede that the government's statutory right of action is different from and broader than the contract rights of the beneficiary. *See, e.g., United States v. Studivant*, 529 F.2d 673, 674-75 (3d Cir. 1976) (the government's right to sue is not limited by the statute of limitations generally applicable to a subrogee where the government has a statutory right of action; instead the federal statute of limitations applies). But the mere fact that the government has a right to bring a lawsuit cannot justify a regulation overriding contract terms having nothing to do with filing suit.

mitted and paid by Medicare *before the expiration of any private plan filing deadline.*" Pet. 16 n.11 (emphasis supplied). If that is so, it is hard to see why the government's recovery efforts would be time-barred. In any case, even if the government were in fact unable to organize its program so as to seek recovery on a timely basis, that is merely a reason for it to seek a change in the statute; it is *not* a reason for this Court to authorize a power that is not in the statute now.[17]

Finally, the government argues that the recent legislative history of the MSP statute shows that Congress confirmed the agency's claimed override power. In fact, if anything, that history shows the *opposite*. The history the government cites states that once the agency has identified potential primary payers through Data Match, "Congress intended that '[a]ny overpayment made by Medicare . . . would also be recovered from liable parties *according to existing rules* governing Medicare Secondary Payer and overpayment recovery.'" Pet. 19 (emphasis supplied) (citing H.R. Rep. No. 247, 101st Cong., 1st Sess. 1023 (1989)). But this passage is included in a report dated September 20, 1989, two months *before* the claims-filing override regulation was adopted on November 13, 1989 (54 Fed. Reg. 41,716). Thus, the "exist-

[17] The government also advances a new statutory argument it did not raise in the lower courts. It now says that even though the statute authorizes recovery by HCFA only where payment "could be made" or "is required" under a private plan, since the plan is effectively "revised" by the government's claims-filing override regulation, payment "is required" by the plan. Pet. 16-17. This, of course, is circular, and assumes the existence of the claimed override authority. The government appears now to locate that authority in section 1395y(b)(1). But that paragraph does nothing more than prohibit certain kinds of group health plan provisions, and requires that those over 65 be offered the same benefits and "under the same conditions" as those under 65. The paragraph nowhere dictates the content of those "conditions," and it certainly does not authorize the agency to override any of the conditions.

ing rules" to which the report refers did *not* include *any* claims-filing override provision. If this report is evidence of any congressional intent, it is at best congressional approval of the old rules, not those at issue in this case.[18]

In summary, the Court of Appeals' review of the claims-filing override regulation presents a garden-variety statutory construction case employing settled principles and involves no issue warranting this Court's review. The same is true of the TPA regulation.

b. In determining the validity of the TPA regulation, the Court of Appeals was required to determine whether third-party administrators who make payments on behalf of plans or private insurers are entities "required or responsible . . . to pay . . . under a primary plan. . . ." 42 U.S.C. § 1395y(b)(2)(B)(ii). Both Judge Henderson and Judge Williams held the regulation invalid and both did so by applying this Court's decision in *Chevron U.S.A., Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984).

Thus, relying on record materials showing that TPAs merely process claims for a fee and make payments on claims solely from funds provided by another entity, Judge Henderson found that the TPA regulation contradicted the "unambiguously expressed intent of Congress." Pet. App. 34a (citing *Chevron*, 467 U.S. at 842-43). Judge Williams, on the other hand, found the statutory language arguably ambiguous, and therefore invoked the require-

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[18] The government also points to the fact that in 1989 Congress authorized the obtaining of taxpayer information back to 1987. Pet. 20. But this hardly shows that Congress intended to authorize retroactive overriding of contractual claims-filing requirements. Instead, all it shows is that HCFA is authorized to secure information from other government agencies to assist in identifying dual coverage situations both to avoid improper payments in the future and to secure reimbursement to the extent a source of private coverage is liable.

ment of *Chevron* that the TPA regulation must be upheld if the agency's construction is "reasonable." Pet. App. 8a (citing *Chevron*, 467 U.S. at 845). Judge Williams concluded that the agency's construction is not reasonable, however, because, among other things: (1) if valid, it would authorize the agency to reach the "wholly unreasonable" result of holding liable any entity that has any duty to pay claims, including such agents as banks (Pet. App. 8a-9a); (2) holding TPAs liable merely because it may not always be clear which entity is in fact liable for payment under a given plan is not a "justification for imposing it on a party who—by perfectly clear contract—is plainly not liable" (Pet. App. 9a); and (3) "the record . . . does not come close to showing that HCFA will be hamstrung or even perceptively inconvenienced unless it can proceed directly against administrators" (Pet. App. 10a).

In an effort to relitigate the validity of the TPA regulation and make that validity certworthy, the government makes two contentions. First, it says that it will face "serious difficulties" if the agency is prohibited from proceeding against TPAs. Pet. 22. As noted, however, Judge Williams reviewed the record and found that it "does not come close" to showing that the government will face any difficulty at all. Obviously, this Court should not grant review to reconsider the record evidence on this point.

Second, the government attempts to create an important legal issue from the TPA regulation by lifting a sentence out of context from Judge Williams' opinion and then asserting that that sentence signals the D.C. Circuit's adoption of a new standard that departs from *Chevron*. After reciting the numerous reasons why the TPA regulation is unreasonable and why the agency's proffered justifications for it are either "odd," a "complete jumble," or supported by "no evidence" (Pet. App. 9a-10a), Judge Williams stated:

> Unless HFCA can come up with stronger reasons to support subjecting third-party administrators to recovery actions, we do not think they can reasonably be considered "required or responsible under [the MSP statute] to pay . . . under a primary plan" within the meaning of 42 U.S.C. § 1395y(b)(2)(B)(ii). *We agree with HCFA that if such actions were necessary to accomplish Congress's goals, HCFA's construction of the statute would be reasonable.* But the record before us does not come close to showing that HCFA will be hamstrung or even perceptibly inconvenienced unless it can proceed directly against administrators.

Pet. App. 10a (emphasis supplied).

The government says that this constitutes a new, erroneous D.C. Circuit requirement that all agency regulations must be shown "necessary to accomplish Congress's goals" in order to be upheld. Thus, at one point in its Petition the government contends that the D.C. Circuit's decision "rests in critical part on a novel principle of judicial review . . . that is inconsistent with *Chevron*. . . ." Pet. 14. Later, the government becomes even more extravagant and contends that "the court struck down [the TPA regulation] even though two judges agreed that the statutory language was ambiguous, and that the agency's interpretation of that language was plausible." Pet. 29. According to the government, this "mistaken approach to judicial review of agencies' statutory interpretation threatens to disrupt settled principles of review under *Chevron*," particularly since it comes "from a court that hears a disproportionate number of cases involving federal agencies' interpretations of the statutes they are charged with administering." *Id.* None of this is correct.

In his opinion, Judge Williams expressly relied on this Court's "reasonableness" standard from *Chevron* in assessing the validity of the TPA regulation. Pet. App. 5a, 8a. In particular, he stated that the court would "defer to

[agency] judgments," unless "they seem wholly unsupported or if they conflict with the policy judgments that undergird the statutory scheme." *Id.* at 8a. His later use of the word "necessary" in the quoted passage merely indicates that notwithstanding all the other indications that the agency's construction was not reasonable, he still would have upheld it if the agency could otherwise have shown it necessary to achieve Congress' goals. Yet, far from doing so, he found the agency had not even shown that it would be "perceptibly inconvenienced" without the regulation.

This does not constitute adoption of a new standard. It is a single explanatory sentence in a single opinion from a single judge who plainly invoked *Chevron*'s standard. Moreover, this Court reviews judgments, not opinions, and in this case Judge Williams' opinion is not even the opinion for the Court. Furthermore, nowhere either before or after Judge Williams' opinion has the D.C. Circuit *ever* indicated that the *Chevron* standard requires an agency to show that its regulations are "necessary" to be valid.[19] And, as shown, that is *not* what Judge Williams himself required in this case. Finally, the suggestion that the D.C. Circuit struck down a regulation it found "plausible" is completely without foundation. Judge Henderson

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[19] *See e.g., Alabama Power Co.* v. *EPA*, Nos. 94-1170 & 94-1329, 1994 WL 662739, at *3 (D.C. Cir. Nov. 29, 1994); *Village of Bergen* v. *FERC*, 33 F.3d 1385, 1388 (D.C. Cir. 1994); *National Classification Comm.* v. *United States*, 22 F.3d 1174, 1176 (D.C. Cir. 1994). *Accord, Public Citizen, Inc.* v. *FAA*, 988 F.2d 186, 191 (D.C. Cir. 1993); *Natural Resources Defense Council, Inc.* v. *Reilly*, 976 F.2d 36, 40 (D.C. Cir. 1992); *Nuclear Info. Resource Serv. v. NRC*, 969 F.2d 1169, 1173 (D.C. Cir. 1992) (*en banc*); *Hazardous Waste Treatment Council* v. *Reilly*, 938 F.2d 1390, 1395 (D.C. Cir. 1991); *Chemical Mfrs. Ass'n* v. *EPA*, 919 F.2d 158, 162-163 (D.C. Cir. 1990); *Natural Resources Defense Council, Inc.* v. *EPA*, 907 F.2d 1146, 1153 (D.C. Cir. 1990); *Public Citizen, Inc.* v. *NRC*, 901 F.2d 147, 154 (D.C. Cir.), *cert. denied*, 498 U.S. 992 (1990); *Ohio* v. *United States Dep't of the Interior*, 880 F.2d 432, 441 (D.C. Cir. 1989).

found the TPA regulation directly "contrary to the MSP statute's plain text" (Pet. App. 35a) (footnote omitted), while Judge Williams found that TPAs could not "reasonably be considered" to be "responsible" entities "within the meaning of" the statute (Pet. App. 10a).

Accordingly, as with the claims-filing override regulation, the TPA regulation presents no certworthy issue.

c. The remaining issue presented in this case concerns the government's attempt to apply its regulations retroactively. The Court of Appeals held that those regulations are subject to the ban on retroactivity announced by this Court in *Bowen* v. *Georgetown Univ. Hosp.*, 488 U.S. 204 (1988). In that case—which construed a different part of the Medicare statute here at issue—this Court held that "a statutory grant of legislative rulemaking authority will not . . . be understood to encompass the power to promulgate retroactive rules unless that power is conveyed by Congress in express terms." 488 U.S. at 208 (citation omitted). Because "no express authorization of retroactive rulemaking" appeared anywhere in the statute, this Court held that such rulemaking was prohibited. *Id.* at 213, 214-15 (footnote omitted). The Court of Appeals necessarily held *Bowen* to be controlling here and accepted the government's concession that the ban on retroactive rulemaking applies equally to "legislative" and "interpretative" rules, the latter being the kind at issue here. Pet. App. 24a, 26a.

Nevertheless, the Court of Appeals recognized that there is no similar ban on retroactive action by agencies in the context of *adjudication*. Pet. App. 29a-30a. As Justice Scalia noted in his concurring opinion in *Bowen*, "the retroactivity limitation applies *only* to rulemaking. Thus, where legal consequences hinge upon the interpretation of statutory requirements, *and when no pre-existing interpretive rule construing those requirements is in effect*, nothing prevents the agency from acting retroactively

through adjudication." 488 U.S. at 224 (emphasis supplied) (citations omitted). Accordingly, the Court of Appeals held, if HCFA were to bring an independent enforcement action under the MSP statute, it could seek to apply its current view of the statute to past transactions, so long as that view was consistent with "whatever pertinent rules were in effect at the time of the transactions." Pet. App. 30a-31a. However, and necessarily, in that enforcement action the agency could *not* seek deference for any regulations designed to apply retroactively to those transactions, for to do so would effectively accomplish the retroactive rulemaking *Bowen* prohibited. Pet. App. 30a-31a. As the Court of Appeals stated, "a court that . . . defers to interpretive rules promulgated after the transaction at issue is obviously giving those rules retroactive effect." Pet. App. 30a.

All of this is nothing more than a straightforward application of *Bowen*, a decision this Court strongly reaffirmed only nine months ago in *Landgraf* v. *USI Film Prods.*, 114 S.Ct. 1483, 1496-97, 1500 (1994). Nevertheless, in its Petition the government claims that "[t]he decision below raises fundamental issues concerning interpretive rules that require clarification by this Court." Pet. 25. According to the government, those "fundamental issues" are: (1) whether "the same degree of judicial deference" should be accorded an agency interpretive rule as an agency adjudication; and (2) whether an interpretive rule should be accorded the same deference whether being applied prospectively or retroactively. *Id.* at 25-26. In fact, however, both those questions are already well-settled by this Court, and the Court of Appeals simply followed this Court's decisions regarding those questions. Regarding the first question, the Court of Appeals expressly noted that it defers to agency interpretive rules (Pet. App. 27a-28a) just as it does to agency adjudications (Pet. App. 28a-30a), as required by *Martin* v. *Occupational Safety & Health Review Comm'n*, 499 U.S. 144,

156-57 (1991). And, with regard to the second question, the Court of Appeals expressly noted that it would not defer to retroactive interpretive rules because to do so would contradict *Bowen*. Once again, therefore, the government's efforts to create an important issue in this case are unavailing.[20]

For all these reasons, nothing in any of the three parts of the Court of Appeals' decision warrants this Court's review.

II. THE AGENCY REGULATIONS AT ISSUE DO NOT OTHERWISE MERIT REVIEW BY THIS COURT.

In addition to arguing that this case raises important legal questions—which it does not—the government seeks review on the ground that the regulations at issue are of such fundamental, nationwide importance that they merit review on that ground alone. Thus, the government asserts that "significant administrative disruption and public costs . . . will result from the court of appeals' judgment in this case . . . ." Pet. 30. That is because, according to the government, "[t]he court of appeals . . . has placed unreasonable limits on the Secretary's ability to recover reimbursement for Medicare payments that should have been made by private insurers." Pet. 26.

But the "limits" on the Secretary's ability to seek reimbursement were set by Congress, not by the Court of Appeals. And, as shown, that Court has interpreted and enforced those limits in accordance with well-settled principles established by this Court. If the government does not agree with those limits, it can and should seek a

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[20] Indeed, the government conceded in its rehearing petition in the Court of Appeals that the retroactivity issue was not important standing alone: "We do not seek rehearing of this issue independently of the others, however, because it is of more limited practical importance unless one or both of the other rules is upheld." Gov't Petition for Rehearing, *HIAA* v. *Shalala*, Nos. 92-5196 & 92-5197 (D.C. Cir., filed June 27, 1994) at 15 n.12.

change from Congress. And, given that this is a statute Congress frequently reviews and revises, the agency will have ample opportunity to seek such a change.[21]

Moreover, the two regulations for which the government seeks review have nothing to do with HCFA's asserted attempt to recover "payment that should have been made by private insurers." By definition, the claims-filing override regulation deals *solely* with claims that were never timely presented to insurers or EGHPs, even though timely presentation is an important, negotiated, lawful requirement of their private contracts. *See* pp. 9-11, *supra*. As shown, nothing in the MSP statute invalidates that contractual requirement or requires insurers or EGHPs to ignore it. It is therefore nonsense to suggest that payment "should have been made" by insurers when this negotiated requirement was not met—particularly as to claims that were never presented to those insurers *at all*.

Similarly, the TPA regulation was not designed to hold private *insurers* liable for payment they "should have made." Rather, that regulation attempts to hold the *administrative agents* of employers or EGHPs liable for such payments, and to do so even though the agents have no contractual responsibility for those payments and no funds of their own to cover them. Thus, while HCFA's effort to recover insurance payments that "should have been made" by private insurers is a legitimate one, the two regulations at issue are not part of that effort.

Furthermore, the validity of the regulations at issue is simply not a matter of widespread importance. The gov-

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[21] Significantly, in its most recent amendments to the statute—enacted in October of last year, after the Court of Appeals' decision—Congress again used the phrase "could be made" in describing the agency's reimbursement rights, thereby signaling its agreement with the Court of Appeals' construction of that phrase. 1994 Amendments, § 151(b)(1)(2), 108 Stat. 4434. *See Cottage Savs. Ass'n* v. *Commissioner of Internal Revenue*, 499 U.S. 554, 562 (1991); *Cannon* v. *University of Chicago*, 441 U.S. 677, 691-99 (1979).

ernment itself concedes there is not and probably will not be any conflict among the circuits over the regulations, and that the few cases that have addressed the underlying legal issues may all be settled. Pet. 27-29.

Finally, although the government asserts that this case is of "considerable practical significance to a major federal program" (Pet. 26), it has not actually shown that to be so. More important, it has not shown why such an assertion, even if supported, would be sufficient to warrant certiorari. There are countless cases challenging agency regulations and most could be said to be "significant" to a "major federal program," at least by the standard in the government's Petition. This Court should not grant review by that standard.

CONCLUSION

The regulations in this case were fully and fairly reviewed by the Court of Appeals. Neither the regulations themselves nor the legal issues they present are sufficiently important to warrant this Court's review. The Petition should be denied.

Respectfully submitted,

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